

that Medicare and Medicaid puts into place today. And what the Democratic bills will do is going to ration care much, much, more. Seniors are not going to get the care that they need and deserve, and thus it's going to be detrimental to their health.

Mr. AKIN. So we've been talking a little bit bad about these Democrat proposals. This is something that Congressman LUNGREN's been hitting, and that is it reduces health choices. Freedom is about increasing health choices, not reducing them. It raises premiums as long as there's even going to be premiums, it delays and denies care, \$500 billion in Medicare cuts.

Mr. DANIEL E. LUNGREN of California. Would the gentleman yield?

Mr. AKIN. I do yield, yes.

Mr. DANIEL E. LUNGREN of California. On the \$500 billion. As part of that \$500 billion is at least \$133 billion taken out of Medicare advantage. I have 42,000 seniors in my district who are enrolled in Medicare Advantage. What is Medicare Advantage? It is the private option put into the Medicare system when the Republicans were in charge. There's a new idea that actually was implemented. It is tremendously successful across the country. Yes, they've got some imperfections that we need to work on, but their bill would destroy it.

There is no better evidence that they want to destroy private options than the fact that this bill destroys the only private option that currently exists in the Medicare system, Medicare Advantage.

Mr. AKIN. In our last minute or two, what I might do is share something personal because I came to this Congress 9 years ago, and they have a little medical clinic that's downstairs, and the medical clinic gives you—if you want to spend about \$400, you can get a test, you can get a physical.

□ 1600

I hadn't had a physical in years because I had some sort of State HMO policy. I never could see my primary care doctor. I don't even think he existed. I could never get an appointment.

So I go down there and find out I was bulletproof, as I thought, except for one detail. I had cancer. So when you use the "cancer" word around me, my ears pick up a little bit. I take a look at how does it work when these governments run and deal with cancer. Here's your survival rate for men in the United Kingdom, 44.8 percent. It jumps up here quite a number percent to 62.9 among men in the United States. And we want to go over and make ours like that? I don't think so.

I yield to my friend from Georgia, last minute.

Mr. BROUN of Georgia. Well, you are exactly right. The reason that the survival rates—these are 5-year survival rates for people with cancer. Women with breast cancer, you look at your chart, which is accurate. This comes

from independent data. Five-year survival rate for cancer. Actually, for breast cancer, it's over 90 percent, where in Great Britain it's much less than that. But all cancers for women on your chart is 66.3 percent for women, 5-year survival rate, and in the United Kingdom, 52.7 percent. Why is that? The reason it's that way is because they have delayed diagnosis because of the ration of care because of the constraints.

Mr. AKIN. So you have rationed care. Rationed care means you've got to wait longer in line. Waiting with cancer is not a good deal.

Mr. BROUN of Georgia. You don't get that evaluation, so you have delayed diagnosis. So people have late diagnosis, and then their treatment outcomes are not as good.

So, as a physician, I can tell you that ObamaCare is going to cause people to have to wait for all treatments, wait for the diagnosis, and they're going to have poor outcomes. So it's going to hurt everybody.

Mr. AKIN. And "poor outcomes," that's doctor's talk for you're going to die, isn't it?

Mr. BROUN of Georgia. Well, that's correct. There is going to be a greater percentage of people that are going to die because of it.

Mr. AKIN. Thank you, Madam Speaker.

HEALTH CARE

The SPEAKER pro tempore. Under the Speaker's announced policy of January 6, 2009, the gentleman from Michigan (Mr. STUPAK) is recognized for 60 minutes as the designee of the majority leader.

Mr. STUPAK. Madam Speaker, thank you for allowing me time to speak on the floor on health care.

I couldn't help but listen to the last group, my colleagues on the other side of the aisle, talking about health care and calling it all kinds of names, about everything but what it is.

The health care in America, the bill that we're marking up, H.R. 3200, is America's Healthy Choice Act. There is no such thing as "ObamaCare." I guess we use that just to try to scare people, like much of the rhetoric I heard in the few minutes I was here.

I can't help but notice that the folks who were speaking on the floor were not in the committee of jurisdiction where H.R. 3200, the House health care bill, actually went through; those of us who spent months working on this legislation and over 2 weeks in committee considering amendments and making sure that this is a bill that actually helps America and all Americans.

As we Democrats look at health care, we take a little different perspective. My colleagues in the last hour said, Well, if it ain't broke, don't fix it. Well, for the American people, health care is broken and it does need fixing. That is why we are bringing forth this legislation, H.R. 3200.

In fact, I have a picture here of a family from Colorado who actually came and testified—and I will talk more about them during this next 60 minutes—on their concerns. But these are the folks that we are trying to help: Average Americans who work hard, play by the rules, pay their bills, think they have good health insurance until someone gets sick, and then they are left financially ruined.

I sit as chairman of the Energy and Commerce Subcommittee on Oversight and Investigations. For the last 2 years, we've been taking a look at the private insurance industry. We have held hearings on the insurance industry's practices on nursing homes, long-term care insurance, Medicare Advantage that the group spoke of, and most recently, we've been looking at hearings on the private health insurance market.

The findings of these hearings really highlight the need to address the abusive practices, terms such as "rescission." That's when the insurance company takes a look at your insurance policy when you get sick and finds any excuse to rescind your policy. Or "purging." That's when the insurance companies for small businesses in particular, they jack up the price, because under Federal law, if you're a small business, they can't cancel you, so they jack up the price so bad that you can no longer afford it. It's called purging. Or the problem of uninsured, which millions of Americans are facing.

So in June, July, and August, we spent a lot of time looking at the most egregious practices found in the insurance industry: abuse of consumers, the practice of rescission in the individual insurance market, and, as I said, underinsurance.

Take a look at rescissions. Every night when Americans go to sleep—more than 45 million Americans do not have any health insurance—they do so with the nightmare scenario that if they develop a catastrophic illness or are unable to pay for their treatment, what happens to them? This fear causes many hardworking Americans who are not covered by an employer or government-sponsored health care to purchase an individual insurance policy. But those Americans fortunate enough to be able to even afford an individual policy—an individual family policy now is about \$13,000 a year. But if you're fortunate enough to be able to buy individual health care coverage, you're not immune from this nightmare scenario of health care, not having it there for you and facing financial ruin, and that's because of a little thing called rescission.

Let me tell you quickly about what happened to Otto Raddatz. Otto Raddatz was a 59-year-old gentleman from Illinois. He owned a restaurant. He had insurance all his life. He was diagnosed with an aggressive form of non-Hodgkin's lymphoma. That's a cancer of the immune system. He underwent intensive chemotherapy and

was told that he had to have a stem cell transplant in order to survive. He had insurance coverage. He said, no problem, my insurance will cover it. It should be provided by my individual policy.

He was scheduled to have the procedure performed, and the weekend before he was scheduled to have his transplant, the insurance company suddenly told him it was going to cancel his insurance. Otto could not pay for the surgery without his health insurance, and the surgery was therefore canceled because the hospital wasn't going to perform the stem cell transplant without payment.

The insurance company told him that it found out that when he applied—now, this is years later—he applied for his health insurance. Years later, once they found out he has to have this stem cell transplant, they go back and look at his application. On his application, the insurance company said it showed that he might have gallstones and he might have an aneurysm, which is a weakness of the blood vessel wall. In fact, testimony showed Otto's doctor never told him he had gallstones, never told him he had an aneurysm. Otto told the truth on the application, but the insurance company heard nothing of it. They said, You didn't tell the truth on your application; therefore, we're canceling you. The insurance company was going to rescind his policy, effectively tear up the contract as if it never occurred, and Otto would be left without a stem cell transplant.

Otto made a desperate plea to the Illinois State attorney general, and also his sister was an attorney. They went after that insurance company to reverse the decision. Here's what Otto said when he wrote to the insurance company:

"I was diagnosed with non-Hodgkin's lymphoma . . . It is a matter of extreme urgency that I receive my transplant in 3 weeks . . . This is an urgent matter! Please help me so I can have my transplant as scheduled. Any delay could threaten my life."

What did the insurance company say after that plea? Too bad. You falsified your application, even though Otto never knew he had gallstones or an aneurysm.

The Illinois attorney general launched an investigation, confirmed that Otto's doctor never told him about the test findings, and the attorney general sent two letters to the insurance company saying reinstate his policy. The company relented, Otto received his stem cell transplant, and he was able to live 3 more years before he died earlier this year. Otto was one of the lucky ones. The attorney general went to bat for him, and his sister, who was an attorney.

In our Oversight and Investigation Subcommittee, we have looked into this investigation into the practice of health insurance rescission and the results are alarming. Over the last 5

years, almost 20,000 individual insurance policyholders have had their policies rescinded by the three biggest insurance companies who testified at our hearing. These 20,000 individuals lost their insurance because of some honest mistake, or they did what the agent told them to put on their application only to have the parent company rescind them when they got sick. They saved the insurance industry \$300 million. That's not counting all the follow-up tests. That's just what they saved by canceling these 20,000 people.

So these big insurance companies, like Assurant, UnitedHealth Group, and WellPoint, when we looked at it, here's what we found out:

These three companies, they conducted investigations with an eye toward rescinding in every case in which a policyholder submits a claim relating to leukemia, breast cancer, or a list of 1,400 serious or costly medical conditions;

they rescind policies based on an alleged failure to disclose a health condition entirely unrelated to the policyholder's current medical problem;

they rescind policies based on the policyholder's failure to disclose a medical condition that their doctors never even told them they had;

and they rescind policies based on innocent mistakes by policyholders in their applications. And they not only rescind for the applicant, but they will rescind the policy for the whole family, leaving all the family members without health insurance.

Our investigation also found that at least one insurance company, WellPoint, actually evaluated their employees' performance based in part, and put reward systems in, on the more you rescind, the more money you save the company, the bigger bonus you receive. In fact, the starting point was you had to save \$10 million for WellPoint and you got a pretty good bonus. You're rated on a scale of one to five.

These practices reveal that when an insurance company receives a claim for an expensive lifesaving treatment, some of them will look for any way, any excuse to avoid having to pay for it. This is eerily similar to what we found last year in our investigation on long-term health care insurance where sales agents for the insurance companies would sell policies to seniors and then change the policies once the enrollee was locked into a plan and making payments.

These insurance companies who engage in this rescission practice argue that it's entirely legal, and, in part, they are, but that goes against the whole point of insurance. When times are good, insurance companies are happy to sign you up and take your money in the form of premiums, but when times are bad, or if you happen to get diagnosed with one of these 1,400 different little characteristics they have in their computer program and you're afflicted with a cancer or some

other life-threatening illness, that's the time when the insurance company is supposed to honor their commitments to you based on the premiums paid, and in your time of need they should be there to help you. Instead, some of the insurance companies use a technicality to justify breaking its promise at a time when patients are too weak to fight back.

I asked the three CEOs of these big insurance companies, I said, Look, we've had this hearing today. We've had extreme conditions where you've rescinded people who made honest mistakes on their application. Will you commit today that your company will never rescind another policy unless there was broad misrepresentation in the application? Every one of the insurance companies' CEOs said, No, we will continue the practice.

So that's one of the reasons why we need to pass comprehensive health care reform. Congress can and must curb this abusive practice, put an end to this unconscionable practice of rescinding people. We should not have caps on how much insurance has to pay or caps on how much you're covered. Coverage in your health care shouldn't depend on your ability to pay; it should depend on the illness you're suffering from, that you get proper treatment.

In H.R. 3200, our health care bill, there are no preexisting conditions. If you have a preexisting condition, you can't be denied insurance.

Last week, our subcommittee revisited the private health industry practices on underinsured. Let me just show you what underinsured is. Underinsured are people who have health insurance. Unfortunately, when they get sick, and because of high deductibles or copays or a limitation on policy, lifetime cap, or a limit on number of services or specialists you can see, when they get sick, their insurance is almost worthless. It doesn't cover anything.

More than one-quarter of adults under the age of 65 with medical bill burdens and debt were unable to pay for basic necessities. So, if you're one of the underinsured—and according to testimony, 116 million adults in this country, 42 percent, 116 million of them have problems paying their health care bills. Sixteen percent are unable to pay for basic necessities—food, heat, rent—because of medical bills. Another 39 percent used up all their savings trying to pay their medical bills. Another 10 percent took another mortgage out on their house to try to pay for medical bills.

□ 1615

Thirty percent put it on credit cards. With the interest on credit cards, I don't know how you could afford to pay off your credit cards, let alone the interest on the credit cards. Sixty-one percent were insured at the time care was provided.

These people are uninsured because they can only afford to purchase a limited policy. Policyholders believe they

have adequate coverage only to find out that there are limits buried within the fine print of that policy, such as caps. So, regardless of how you define this fragile financial group, the sad consequences of being underinsured can be devastating, leading to financial ruin, to bankruptcy, and to making medical decisions based on cost rather than care.

If you take a look at it, as the health insurance skyrockets, more Americans are finding they can only afford bare-bones policies. According to the Journal of the American Medical Association in 2007, they said 62 percent of all bankruptcies in the United States were related to medical costs. This was 62 percent of all bankruptcies. Of those bankruptcies in 2007, 78 percent of them had insurance. So, of all of the bankruptcies, 62 percent were related to medical costs, and 78 percent of those people actually had insurance. They were the underinsured. Many of them were well-educated, and they owned their own homes. They were the middle class. Unfortunately, they were underinsured, and their health insurance did not cover their medical costs.

The Commonwealth Fund reported and testified at our committee that more families are experiencing medical bill problems or cost-related delays in getting medical care. In 2007, two-thirds of all adults, 116 million people, who struggled to pay medical bills and who went without needed medical care because of cost, were uninsured for a time or were underinsured.

Let me show you this picture. This is Catherine Howard. She testified at our hearing. At 29 years old, Catherine had breast cancer and survived to tell her story. Being young and healthy, with a limited income and just starting out in her professional career, she chose a low-premium, high-co-pay health insurance that left her in financial shambles after her breast cancer.

At the time of her illness, she was earning just \$20,000, but at the time of her illness and when she got done, her outstanding medical bills were \$40,000. Catherine was unable to work through the surgery, through the chemotherapy and through the radiation for 2 years. So, when you put it all together, she was in a very tough financial situation. To her credit, she did not declare bankruptcy. She survived her breast cancer, but she is paying \$1,800 a month on her medical bills.

Let me go back to the original picture. This is the Null family from Colorado. The young lady right there is Tatum Null. She was diagnosed with liver failure at the age of 7. David had bought health insurance, an individual family policy, to cover them in emergency situations.

He told the agent, I don't want one for the common cold. I need a policy that will take care of my girls and my family if something serious happens.

They sold him a policy. Then, while away on vacation, suddenly Tatum's kidney started shutting down, and they

had to rush her to the hospital. They put her on life support. They told David Null, Tatum's dad, that she needed a \$560,000 kidney transplant. They looked at his insurance policy. The insurance policy would cover \$25,000 to \$30,000 in hospital costs.

They said to David Null, Before we can save Tatum's life with a transplant, you have to put down \$200,000.

His daughter is on life support. He is at the hospital. They find out their insurance policy is no good. They say you have to come up with \$200,000 or your daughter is going to die. What are you going to do?

Well, without really much of a hope or a prayer, David and the hospital officials got together, and they decided that if they could put David and the Null family on Medicaid, the government-run, government-sponsored Medicaid health care, the entire hospital bill would probably be paid retroactively. The catch is, once you go on Medicaid, you have to have low income. The Nulls could only earn \$1,614 a month; or they would lose their Medicaid coverage, which paid for Tatum's medication to prevent organ rejection and which can cost thousands of dollars each month.

Let me show you another person. This is Thomas Wilkes. His dad, Nathan, had an employer who provided health insurance with a \$1 million limit for each family member. \$1 million. Unfortunately, \$1 million doesn't go very far when you're 6 years old and when you're diagnosed with severe hemophilia.

Even though the Wilkeses paid another \$25,000 each year out of pocket, in just over a year young David here would go through the \$1 million cap on their medical expenses. The Wilkes family is now on their third insurance policy. They're bumping up against the cap, and he doesn't know what he's going to do for his son, who needs expensive medical treatment because he's a hemophiliac. He does not know how he is going to be able to afford his son's life-saving medical treatments, once again, when they hit the \$1 million cap.

Each of these individuals, the Wilkes family and the Null family, did what they thought was right for their families. They purchased health insurance. They worked hard. They paid their premiums, but they're still left in financial ruin.

Each of us knows a family member, a relative, a friend who did not go to the doctor when sick or who skipped a dose of medication, who failed to fill a prescription, who intentionally missed a medical test or a follow-up appointment or who didn't see a specialist because he couldn't afford the service, the medication or the test he needed.

I would hope every American, as we debate health care, would take time to look at their own insurance policies and would really understand what medical conditions those policies cover or don't cover. What's your co-pay? What are your potential out-of-pocket ex-

penses? Do you have a lifetime cap or are services limited underneath that policy?

In a couple of weeks, we hope the U.S. House of Representatives will vote on H.R. 3200, America's Affordable Health Choices Act of 2009, because H.R. 3200 does not allow the insurance companies to rescind your policies when you get sick. It does not have a lifetime cap on benefits. It puts a limit on what you have to pay out-of-pocket. It covers all Americans, and you can't be discriminated against because of preexisting injuries or illnesses.

Only with the passage of meaningful health care reform, then and only then will Americans not have to worry about how to obtain medical care for their families while remaining financially secure.

Yesterday, our subcommittee, again, did another investigation of the private insurance market. We focused on the challenges faced by small businesses. I said earlier that, in small businesses, you can't cancel. Once you have a small business, underneath the HIPAA provisions, you can't cancel. You're guaranteed a renewal every year; but insurance companies, because they feel they're not making enough money, can jack up their rates. There is no limitation on how much you have to pay.

Small businesses are really the cornerstones of the American economy. As one of them testified, when the businesses testified the other day, they really are the American Dream. Small businesses employ 59 million Americans, and they have created a quarter of our Nation's jobs from 1992 to 2005.

Our subcommittee sent documents to the six leading health insurance companies that all sell policies to small businesses across the country. We wanted to know how they set their premium rates and what some of the largest premium rate increases have been in recent years. Here is what we learned:

The insurance companies take advantage of lax State laws and regulations, and they purge out small businesses because they're unprofitable if someone gets sick. Because Federal law guarantees small businesses can't be denied insurance once they have it, they impose unpredictable, increasingly unaffordable premium increases. These unsustainable premiums force the small businesses to drop their health insurance because it's no longer affordable. Thus, a small business is really purged. Their premium increases are based on factors that are beyond the control of the small business, such as: every covered employee and their families, what are their health statuses? What's the size of the small business? What's the age? What are the genders of these employees? As a result of these discriminatory practices, small group premiums are subject to unpredictable and enormous increases. Here is what we learned:

In January 2008, one insurance company offered a 232 percent premium

rate increase to an engineering services company in Kentucky. The number of employees in the plan had dropped down from eight to one, so its policy went up 232 percent.

This year, another insurance company offered a small technology firm in Georgia to renew its current HMO insurance policy with a 214 percent increase in their premiums. The basis for the rate hike was that the average worker in the firm had become older because they had laid off so many younger workers, and most of the workers were going to be female. The size of the company decreased, and the workforce was older.

By the way, if you're in a small business, you pay more for female workers than you do for male workers.

These large annual premium increases can devastate these small firms. Businesses are struggling to stay afloat in this economic downturn. Health insurance costs consume even a greater portion of a company's profits, and they make it harder every year to cover their employees.

Yet, even before the most recent economic downturn, the costs of employer-sponsored health insurance was the primary concern of small businesses. The average family premium for a small business, if you're going to cover your family, is nearly \$13,000. That has gone up 123 percent since 1999. Meanwhile, the median family income only grew 29 percent. Because of these high costs, nearly a quarter of all small businesses are making difficult decisions on whether or not to provide health care. Small businesses are shouldering a greater burden of the cost.

Over the last 10 years, workers' contributions for health care premiums have doubled while their deductibles have greatly increased. Less than 50 percent of the smallest firms, those with fewer than 10 employees, offer coverage. As a result of reductions in small group coverage, more than half of all small businesses in 2007 were uninsured or underinsured. It's clear that the high cost of health insurance is crippling our businesses.

You know, when we take a look at small businesses and at the group that testified before us this week, one was a Mick Landauer. He is from Iowa. He owns a muffler and brake shop, and he has owned it for 30 years. He has shops in Iowa and Illinois. At his shops, he employs 11 workers. This year, he was quoted an increase in his premium of 42 percent. It went up 42 percent from last year. Mr. Landauer believes that the increase is due to his own congenital heart condition which has required three surgeries in the past and will require possibly more in the future. This year, instead of accepting the 42 percent increase, he negotiated with his insurance company that the deductible will go up.

So, if you're under a plan and if you're a single person, besides paying your monthly premium, your out-of-

pocket cost is \$8,000 before you can access it. If you're a family, your out-of-pocket cost is \$16,000 before you can access the health care plan. Plus, you've got to pay your monthly premiums.

Now, next year, he's telling us his company can't afford this anymore. He wants to provide his employees with health insurance. He is probably going to drop himself off his business plan since he is the one with the congenital heart condition. He believes the right thing to do is to provide his employees with health care. He's trying to do the right things.

Mr. Bruce Hetrick is from Indianapolis. He testified the other day. He had 15 employees. His company has received double-digit increases every year from his health carrier, Anthem. His insurance plan also covered his late wife, who developed breast cancer. In her last year of life, she ran up bills of \$300,000. Unfortunately, she died. In that year, when his wife was so sick, they increased his health insurance by 28 percent.

After his wife passed away, since they were still in that policy year, he asked Anthem, What will it cost now that my wife is no longer on?

They said, Instead of a 28 percent increase, we're only going to increase it 10 percent.

Then there was Fred Walker from St. Petersburg Glass and Mirror in St. Petersburg, Florida. It is a company he started 15 years ago, and he has always offered health insurance because he wanted to have good employees. His carrier, United Health, has increased his premium rates every year, including a 14.6 percent increase this year.

To keep his business afloat during this downturn, he was thinking about dropping his health care coverage because he could no longer afford it. It was a 15 percent increase from last year, and he just couldn't afford it. He was talking to his employees about it. One of his employees, the secretary, went to have a breast examination, and she found out she had breast cancer.

To his credit, Mr. Walker decided to do the right things, and he maintains the health care coverage for his workers and especially for his secretary so she can get treatment. To afford the coverage, they had to take out a plan which has a \$6,000 deductible. So, before you make any claim, you've got to pay \$6,000 out-of-pocket plus your monthly premiums. Because the group coverage was renewed, the secretary has been able to maintain some treatment for her cancer.

Again, we're going to vote on America's Affordable Health Care Choices Act of 2009, H.R. 3200. It contains critical insurance reforms that will end these abusive insurance company practices that we see. Under the bill, insurance companies can no longer rescind policies after people get sick based on minor mistakes or on technicalities. The bill prohibits an annual lifetime cap on coverage. You will no longer be denied insurance because of preexisting

injuries, and insurers will no longer discriminate against small businesses based on how small they are or the health statuses of their workers.

□ 1630

We must reform health insurance so small business can compete and American businesses and families can be secure.

In the Energy and Commerce Committee we had the main jurisdiction on the health care bill and spent months looking at it. These are just some of the examples we found and why we need health care. When my colleagues on the other side of the aisle talk, well, it ain't broke, don't fix it. For the American family, health insurance is broken. We do need to fix it.

My friends were saying on the other side of the aisle, we need more competition, we need more choice, you need more choice. Our investigation again shows, there really is no choice.

The market share for large insurance companies by largest health plans in the State, the darkest States, there's only two health plans to choose from, not a lot of competition there. In these lighter blue, it's 70 to 79 percent are covered, like my home State of Michigan, by just two of the large health insurance plans.

Where is the choice? Where the competition? How do you drive down these costs when there is no competition. Actually, there are really only about six main insurance companies, there are about 1,300 of them on the books, but they are owned by about six of the major companies that we talked about here tonight, the lack of competition.

But these are the faces that we are fighting for every day when we try to look at health care. These are the people that we are trying to help out. Like Thomas here, through no fault of his own, a hemophiliac, in just over a year his dad plows through their policy, \$1 million, that is the cap on it and they go through it within about 14 or 16 months. They go through it. Who is sticking up for these people?

Take a look at some of the things, here is one I like looking at, what we have found. Look at this. This is a joke in one of the magazines, one of the newspapers here. It's not really much of a joke for the American people though. Here is the guy who is sick. He has got his oxygen mask on. He has got his denied paper here.

It must be rescinding his individual policy. It says, "Denied." Why? "Look, it costs us nearly \$120 million in deceptive ads to fight health care reform, so there is not enough money left to pay for your stupid little claim."

It's a joke, but it's really not for people who have their insurance policy rescinded. It's really not for the small businesses who are seeing 30, 40 percent increase each year. It's really not for the underinsured who pay their premiums and then they don't have enough money to cover their medical costs.

It's really talk about \$120 million in deceptive ads to fight health care. They are spending over \$1 million a day on ads to defeat H.R. 3200.

I hope that the Members of the House of Representatives will remember people like Thomas here or like Tatum or these families who play by the rules, work hard, pay their premiums, and, when they get sick, are abandoned by the health insurance industry. That's why we need health insurance reform in this country. That's just one of the many reasons.

It's one of the reasons why we hope to have a bill on the floor later this month or early in November so we can vote on this.

We have to bring back some sanity to this health insurance industry. We have got to end their abusive practices, and we must make sure that all Americans and their businesses are secure, not only in their health security but also financially secure as they try to do the right thing, play by the rules, work hard, pay their insurance. Let's make sure there is coverage for them when they get sick.

Mr. WAXMAN. Mr. Speaker, the premise of health insurance is that if you buy a policy, and then get sick, your insurance company will protect you.

But what we heard at the committee's hearing last week on underinsurance—and what we have been hearing throughout our investigations of the private insurance industry—is that that is not how the system works. In reality, we have learned, private health insurance companies have become expert at collecting premiums and then, denying claims.

Our witnesses on Thursday were normal people who had done the right thing and had bought health insurance. But each of them found that, when they needed coverage the most, their policies came up short.

We heard from Nathan Wilkes, who had an insurance plan through his employer. Then, his son, Thomas, was born with hemophilia, an expensive and life-long blood-clotting disorder. Thomas is six years old now, and thankfully, his condition is well-managed. But, he has already exceeded the million-dollar lifetime caps of two separate insurance plans, and the Wilkes' current plan has a \$6 million cap that Thomas is sure to meet soon. As Mr. Wilkes put it, the insurance companies have turned the hourglass over on Thomas again—this time with just a little more sand.

Catherine Howard testified about how, as a healthy 29-year-old, she bought a basic policy that she thought would protect her if she fell while snowboarding. When it was discovered that she had breast cancer, Ms. Howard found out that her plan asked her to pay 30% of the cost of treatments, like radiation, that she needed to survive. Though she feels lucky to be alive, Ms. Howard's coinsurance payments put her into deep debt that she continues to pay off to this day.

David Null bought what he thought was a catastrophic coverage plan. But when catastrophe struck—and his daughter, Tatum, needed a liver transplant—he found out that the plan had a lifetime cap of \$25,000. The Nulls were saved from crushing medical bills only after Mr. Null's small company turned away business so that the family's income was low

enough to qualify for Medicaid, which covered the surgery retroactively.

These stories are not unique. In 2007, there were 25 million underinsured Americans, up 60% from 2003. Underinsurance often causes debilitating medical debts, and a recent study found that 62% of all personal bankruptcies are medically related.

In recent years, insurance companies have been asking Americans to pay more, but are providing them with less. In the last decade, the average cost of a family's premium has risen 131%, but average wages have risen less than a third of that. At the same time, insurance companies are imposing more limits on what their policies will provide. Some policies, like the Nulls' or the Wilkes', have caps that limit the amount the insurer will pay in a lifetime, or a year. Other policies have expensive co-insurance provisions, like Ms. Howard's, that overwhelm the policyholder.

And caps and coinsurance are just some of the problems people face in the private insurance market.

This past summer, our committee held a hearing on the health insurance companies' practice of rescission. This is when insurance companies attempt to cut costs by cancelling policies after people get sick and make claims. The companies go back through their policyholders' application forms, looking for any tiny mistake or omission for an excuse to cancel the policy and deny coverage.

Rescission is unconscionable because it cuts policyholders loose when they need coverage the most. But even worse, when we had insurance company executives sworn in before our committee, we asked them if they would commit to ending the practice of rescission except in cases where the policyholder had intentionally hidden a health condition. The executives refused to make that promise. I think that speaks to the insurance companies' motivations.

Just yesterday, we held a hearing on the small group insurance market. We found that insurance companies sometimes raise small businesses' premiums an astronomical amount—up to 250% in a year—based on factors like the ages and genders of employees, if a single employee had made a large claim the previous year, or if the business had too few employees.

What is so disappointing in our examination of these issues is that, even where small business owners want to do the right thing for their employees, and provide them with access to quality health care via insurance, industry practices and policies today punish their desire to provide proper benefits for their employees and their families. This is wrong, and this is why we need health insurance reform in America.

Indeed, what all of this shows is that the private insurance system is broken. The way insurance is supposed to work is for the insurance companies to spread risk among their policyholders so that, while most people will remain healthy and cost little, the company can pay when other policyholders get sick.

But schemes like rescission, preexisting condition exclusions, lifetime caps, and the way companies are gaming the small group market show that private insurers are not interested in spreading their risk. Rather, they want no risk at all. The companies are happy to insure healthy people who will pay premiums and make few claims, but they want to

exclude, rescind, or purge anyone whose health care costs they might actually have to cover.

Well, that's not how health care works.

The House reform bill, H.R. 3200, would restore the proper balance to the health care system. It would end rescission, preexisting condition exclusions, and lifetime caps. It would place limits on out-of-pocket costs and create a required basic set of benefits so that people know what they are signing up for, and so that they will get what they need. And it would prohibit the problems small businesses face in terms of discrimination based on gender and group size, and in terms of lack of choice.

At Thursday's hearing on underinsurance, Mr. Null told the committee that to him, the biggest tragedy that came out of his daughter Tatum's liver failure was not his family's resulting financial hardship. It was that, under the current system, Tatum's preexisting condition limits her future. He said, "When she asks me what she should be when she grows up, I can't tell her the same thing that you probably tell your kids. I can't tell her she can be anything she wants, and you guys need to fix that for me."

On Thursday, I looked at Tatum and told her that if we enact health care reform legislation, neither her future, nor anyone else's in America, will be hindered by an inability to get health insurance. Please join me in that promise.

GENERAL LEAVE

Mr. STUPAK. Mr. Speaker, I ask unanimous consent that all Members have 5 legislative days in which to revise and extend their remarks and include extraneous material on my special order.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Michigan.

There was no objection.

REPUBLICAN ALTERNATIVES TO OBAMACARE

The SPEAKER pro tempore. Under the Speaker's announced policy of January 6, 2009, the gentleman from Georgia (Mr. BROUN) is recognized for 60 minutes.

Mr. BROUN of Georgia. Mr. Speaker, it is a pleasure to come and talk about health care tonight. I expect other physicians to come and discuss this extremely important issue to the American people.

We keep hearing over and over again from our Democratic colleagues that Republicans have no alternatives. Well, we have got a bunch of binders here. Each one of those contains a Republican alternative to ObamaCare that the Democrats are proposing.

As the staff brings these forward, every single folder is a Republican plan. Every single folder is a different Republican plan. Every single folder offers suggestions and solutions to the cost of health care for all Americans.

Almost every one of those folders, if not every one of them, we could get bipartisan agreement on, if any of these